Public Partner:

The California Health Benefit Exchange Aligned with Medi-Cal

California HealthCare Foundation

ISSUE BRIEF

October 2011

Overview

It is estimated that by 2019 the Affordable Care Act (ACA) will increase the number of people with health insurance nationwide by 32 million. Medicaid is projected to account for about one-half of this increase in coverage.[1] Enrollment in Medi-Cal, California's Medicaid program, is projected to increase by 20% or more beginning in 2014, at which time one in four Californians are expected to have health care coverage through this program.[2] Many low-income individuals are expected to alternate between coverage through Medi-Cal and through the California Health Benefit Exchange (CHBE) due to fluctuations in income.

The demands and opportunities associated with these changes in coverage make supporting and improving the Medi-Cal program essential if the promise of federal health reform is to be achieved. One possible approach is to develop the CHBE as a "public-partner" Exchange, with an emphasis on coordination with Medi-Cal as a strategic priority.

A public-partner Exchange would go beyond what is required by the ACA, which outlines a vision for aligning the systems and processes used by state Exchanges and Medicaid to determine eligibility for, and enroll individuals in, publicly financed and subsidized coverage. A public-partner CHBE would focus on enrolling and retaining eligible, low-income individuals, and maximizing continuity of coverage and care for people who experience changes in income and program eligibility. It would adopt an array of policies and practices that would align with Medi-Cal's efforts to improve the health status and health care outcomes of low-income, high-need individuals. As a close ally of Medi-Cal, a public-partner Exchange would carefully consider the implications of its decisions on Medi-Cal spending and the California state budget, and seek whenever possible to avoid policies that would add to budgetary pressures to reduce Medi-Cal benefits, provider payments, or eligibility.

This paper describes the choices the Exchange would make and the expected effects of those choices if it were to partner with Medi-Cal. However, this vision for the Exchange cannot be realized unless state lawmakers and the program officials who establish and implement Medi-Cal's governing policies are willing to partner with the Exchange and take certain necessary additional steps beyond what is already required by the ACA. In addition, Medi-Cal's policies, systems, and processes would need to be modified to accommodate the needs of the Exchange. (This is briefly discussed under "Public Program Implications" on page 12.) If both the Exchange and Medi-Cal actively pursued a collaborative approach, the Exchange could play an important role in fostering improvements to Medi-Cal including better customer service, greater consumer choice, and higher quality care for millions of low-income Californians.

Values and Benefits

Adopting a public-partner approach for CHBE would help to strengthen and advance the goals of Medi-Cal, which serves as an important societal safety net by providing essential health coverage

Public Purchasers

Besides partnering with Medi-Cal, CHBE could partner with other public and quasi-public programs such as Healthy Families and CalPERS. While partnering with other public purchasers deserves consideration, this paper focuses on Medi-Cal for two reasons. The first is to provide an anchor for an exploration of the opportunities and challenges associated with partnering with California's largest public purchaser in greater depth than would otherwise be possible. The second is that broadening the focus to include other public and quasi-public purchasers would significantly dilute the significance of partnering with any one of them, given the differences in goals and purchasing strategies of these purchasers.

and long-term support to 7.4 million low-income Californians, including children, their families, individuals with disabilities, and the elderly. Low-income Californians are more likely to be in poorer health than the general population, yet they often face numerous barriers to obtaining timely, high-quality health care.[3] Some of these barriers include language, low literacy, physical or cognitive disability, lack of transportation, and difficulty finding primary care physicians and specialists willing to see them. Medi-Cal is also a major source of funding for safety-net providers on which many Californians rely for care.

The Medi-Cal program also faces many challenges. With expenditures comprising 19% of the state budget and costs growing faster than state revenue, Medi-Cal is under constant pressure to slow the growth of state spending via means such as cutting benefits and reducing provider payments.[4]

The potential benefits of aligning CHBE and Medi-Cal are significant. While the influence of Medi-Cal on California's health care delivery system is already substantial, both the likelihood and magnitude of meaningful improvements in quality, efficiency, and outcomes across the state's entire health care system would be even greater if, instead of pursuing different goals or competing strategies, CHBE and Medi-Cal worked closely together as purchasers, providing the marketplace with a coherent and consistent set of signals and incentives.

Another benefit of aligning CHBE and Medi-Cal is that it would improve continuity of coverage and care among individuals who experience frequent changes in income. According to a recent national estimate, half of all adults with family incomes below 200% of FPL will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse, within a year.[5] These eligibility shifts can lead to gaps in coverage and disruptions in care. Moving in and out of health coverage, referred to as "churning," is detrimental to individuals, providers, health plans, and the health system as a whole. As a result of churning, individuals may miss important preventive care, forgo needed medications, or delay treatment. Providers become frustrated when patients don't comply with follow-up care. Health plans waste money marketing to and re-enrolling members in the same plan, costs that are either passed on to Medi-Cal or, in the future, might be to Exchange enrollees in the form of higher premiums. As a public-partner Exchange, CHBE would work with Medi-Cal to align coverage policies and provider networks.

Finally, a public-partner CHBE could help preserve Medi-Cal as the backbone of the health care safety net for all Californians. Medi-Cal faces constant pressure to cut program expenditures. By avoiding activities that would add to Medi-Cal's costs or undermine its efforts to control spending, a public-partner CHBE could help Medi-Cal avert or minimize future cuts in benefits and provider payments.

Although the potential benefits of partnering with Medi-Cal are enormous, there are also big challenges. As with any large bureaucracy, Medi-Cal can be slow to evolve in the absence of a clear consensus or mandate.

In addition, Medi-Cal is not a typical payer or insurer; it is also an instrument of federal and state social policy and a reflection of budget priorities. As such, its payment policies and managed care contracting practices have favored traditional safety-net providers over private providers; it has scaled back outreach and imposed additional barriers to enrollment during tight fiscal times; and it has maintained its historical links with county social services agencies to determine Medi-Cal eligibility for most applicants, despite the de-linking of Medi-Cal and welfare 15 years ago. To fulfill its potential, a public-partner CHBE would have to find a way to thrive within an environment of externally imposed priorities and constraints.

Key Features and Operational Considerations

The Exchange's operations will have implications for the Medi-Cal program and the people it serves, potentially affecting state program costs as well as the quality and accessibility of care available under Medi-Cal. The ACA requires highly integrated systems for eligibility screening and enrollment between the Exchange and Medi-Cal. An Exchange focused on partnering with publicly funded programs would go further than what is required by federal rules. It would ensure that outreach activities are aligned with the goals of both programs, and that systems for eligibility screening and enrollment are particularly attuned to the needs of low-income consumers. A public-partner Exchange would also make it a priority to ensure the health plan options available to beneficiaries maximize access to and continuity of care, and to make sure that performance incentives and any requirements imposed on participating health plans — such as consumer protections and data reporting requirements — are aligned with the goals of Medi-Cal.

Outreach

A public-partner Exchange would coordinate its outreach activities with Medi-Cal to advance a common goal. CHBE would take advantage of outreach resources provided through the ACA to help ensure that low-income Californians in particular are aware of and have access to opportunities provided under the ACA. These resources include grant funding for states to develop programs that provide enrollment information, referrals, and assistance to consumers, and that help resolve individual tax subsidy issues.[6] The ACA also establishes grants for "navigators" who will educate the public, share information, facilitate enrollment, and provide culturally competent support and assistance.[7]

To meet the needs of Californians who apply for publicly funded coverage, a public-partner Exchange could conduct outreach in locations where low-income Californians are likely to be found (for example, popular shopping destinations in targeted communities, libraries, community centers, and schools), through means that are easy to access (such as kiosks). Outreach activities — whether conducted in person, online, or through traditional media — would be coordinated in a culturally appropriate manner, using easy-to-understand instructions and descriptions to help guide applicants with a wide range of literacy skills through their options.

A public-partner Exchange might require that participating agents and brokers be certified in public assistance offerings to ensure that they are able to explain both commercial and public options to consumers and businesses.

There may be times when an ambitious outreach strategy targeting low-income populations may not be aligned with policymakers' goals for the Medi-Cal program. There are nearly 500,000 low-income uninsured Californians who are eligible for Medi-Cal but not enrolled.[8] By simplifying eligibility rules, streamlining the enrollment process, and creating a "culture of coverage," the ACA may substantially reduce the number of eligible-but-not-enrolled beginning in 2014. Alternatively, because millions more will be eligible for Medi-Cal, the number of eligible-but-not-enrolled could grow. Under current

federal law, California is responsible for 50% of the cost of covering those who were eligible for Medi-Cal under pre-ACA rules and, eventually, for 10% of the cost of covering the newly eligible. Consequently, outreach efforts that increased the number of uninsured Californians who enrolled in Medi-Cal would also increase general fund spending.

For this reason, one view of a public-partner Exchange is that it would work with Department of Health Care Services (DHCS) to create a unified outreach strategy. Just as state lawmakers have done with Medi-Cal, the public-partner Exchange might ramp up its outreach efforts among low-income populations when the state is in strong fiscal health. When the state is struggling to balance its budget, the Exchange might shift its outreach efforts to focus on privately insured or higher-income uninsured, tailor outreach to the highest-need individuals, or scale back outreach altogether. Regardless, the Exchange would always endeavor to make it easy to enroll in Medi-Cal for those who want to do so.

Eligibility Determination and Enrollment

CHBE will play a central role in coordinating eligibility for Medi-Cal and for subsidized qualified health plans (QHPs). Draft federal regulations state that "the alignment of methods for determining eligibility is one part of an overall system established by the ACA that allows for real-time eligibility determination of most applicants and allows for prompt enrollment of individuals in the insurance affordability program for which they qualify."[9] Federal regulations also require exchanges to determine eligibility for certain Medicaid applicants, as well as compulsory data sharing between exchanges and Medicaid to facilitate real-time determinations for non-modified adjusted gross income populations.[10]

Furthermore, by January 1, 2014, states must implement a single application form for Medicaid, Children's Health Insurance Program, and exchange QHPs. Beneficiaries must be referred to the appropriate program without having to submit an additional application, or the state risks losing federal Medicaid funding.

A public-partner CHBE would provide a "one-stop shop" for individuals to enroll in coverage across the Exchange and public programs. Per the ACA this process must be web-based, but to meet the needs of California's most vulnerable citizens, it should also be accessible through other means, including a toll-free call center, kiosks in high-traffic areas, culturally competent navigators, and assistance from community outreach workers. Computers may not be accessible for all applicants, and when they are accessible, barriers such as language, education, and physical ability may impede effective navigation of this system. The Exchange's enrollment system would be mindful of these needs.

Further, the CHBE enrollment process should facilitate enrollment into other public programs such as CalWORKs and CalFresh.[11,12] This would help create a first-class eligibility system that ensures that the needs of vulnerable populations are met. The system should also enable individuals who transition from Medi-Cal to subsidy-eligible status or vice versa to move seamlessly, with no interruption in coverage, between Exchange QHPs and Medi-Cal plans.

The Exchange, regardless of its strategic focus, would adopt policies and practices that make it easy for individuals to compare plans across several characteristics, such as quality of care, covered benefits, provider network, and consumer experience. A public-partner Exchange would also allow plans to be compared in terms of whether individuals would have to switch health plans or change regular health care providers if they moved between Medi-Cal and the Exchange.

For example, the Exchange could seek to provide consumers with a directory of health plans and physicians that allowed consumers to easily determine which had

openings for both new Exchange participants and new Medi-Cal enrollees. The Exchange could also provide summary data, such as the percent of a health plan's providers accepting new patients from the Exchange and from Medi-Cal. The CHBE should also make it easy for enrollees of all levels of literacy to understand and analyze plan quality and assess which plans would be the best fit for them and their families.

Continuity of Coverage

To foster continuity of coverage, draft federal regulations require annual eligibility redetermination processes for both state exchanges and Medicaid. A public-partner CHBE would emphasize additional approaches to advance greater continuity of coverage and care for individuals when their income changes. Examples of such guidelines include the following:

- **Adopt 12 months of continuous eligibility for coverage subsidies through the Exchange and/or 12 months of continuous eligibility for Medi-Cal.** To reduce the amount of churning, both Medi-Cal and the CHBE should consider providing 12 months of continuous eligibility to their members. This is currently a federal option for children enrolled in Medicaid, and may be an option for adults pending further Health and Human Services guidance. Under continuous eligibility, Medi-Cal beneficiaries whose income rises would continue to maintain eligibility for the remainder of the 12-month period, though they would have the option of applying for tax-subsidized coverage through the Exchange. Similarly, Exchange participants whose income falls would continue to maintain eligibility for the Exchange, but they would have the option of applying for Medi-Cal. The July 15, 2011 proposed federal regulations on exchange establishment closely follow the ACA mandate that QHPs must have annual open enrollment periods for qualified individuals to enroll or change plans.[13] The proposed rule also requires states to adopt annual redetermination processes. However, federal approval would likely be needed to enact 12 months of continuous eligibility for Exchange subsidies, and state policymakers would need to consider options to adopt the same policy for Medi-Cal.[14] Furthermore, the federal government must clarify whether Medi-Cal is liable when someone chooses to remain in a subsidy plan, and the extent of that liability. Continuous eligibility policies would reduce churning among individuals whose incomes fluctuate temporarily; however, they would only delay churning among those who experience longer-lasting changes in income.

- **Allow former Medi-Cal beneficiaries to maintain enrollment in Medi-Cal plans for a fixed period.** Another approach to addressing the continuity problem may be to allow targeted individuals whose lose their eligibility for Medi-Cal to remain in their Medi-Cal plans.[15] This option, if allowed under federal rules, could be offered to individuals transitioning off of Medi-Cal who become eligible for subsidies through the Exchange when their Medi-Cal plan is not licensed to serve the commercial market and does not offer coverage through the Exchange. Under this approach, individuals would be able to apply their Exchange tax credit toward their premium, and would qualify for the reduced cost-sharing available to all Exchange enrollees at their income level. The premium would be based on the Medi-Cal capitation rate, adjusted for differences in benefits covered through Medi-Cal and the Exchange. Although this approach would not fully address disruptions in coverage, it would be especially effective for beneficiaries who experienced frequent or temporary changes in income. However, federal authority may be needed to apply an individual's tax credit toward a non-qualified plan. Another potential hurdle is that it would require Medi-Cal to develop a process to collect and track premiums, and to establish additional health plan capitation rates that reflect the benefit package provided by Exchange plans. The converse of this approach — to allow

former tax subsidy-eligible enrollees who become eligible for Medi-Cal to remain in their QHP for a fixed period — is also a possibility, but would likely require that QHPs accept Medi-Cal capitation payment rates as payment in full.

Contracting and Choice of Plans

Under federal law, exchanges are responsible for certifying QHPs for which federally funded, sliding-scale tax credits will be made available to those with incomes between 139% and 400% of FPL in 2014. In California as in other states, this certification process will determine the extent to which the health plan options available to low-income individuals are consistent across the Exchange and Medi-Cal.

A public-partner Exchange would adopt a contracting approach aimed at maximizing uniformity among provider networks across commercial and Medicaid lines of business, and thus minimizing the need for individuals to switch plans or providers when their eligibility changes from Medi-Cal to subsidy-eligible (i.e., eligible for CHBE), or vice versa. A public-partner Exchange would also prioritize expanding access to care, improving quality, and reducing costs, particularly for the low-income population. It would be willing to forego some aspects of consumer choice to achieve these ends.

One challenge facing CHBE is that the health plans available to commercially insured individuals in California are largely different from those available to Medi-Cal enrollees (see "Managed Care Enrollment in California" on page 7). One option would be to pursue a BHP that offers consumers with incomes between 138% and 200% of FPL the same health plan choices available to Medi-Cal beneficiaries (see sidebar). Some alternative options for overcoming this challenge include the following:

- **In each county, the Exchange could contract with at least one Medi-Cal managed care plan that meets state and federal requirements.** To advance goals related to continuity of coverage and care, a public-partner Exchange could contract with at least one Medi-Cal managed care plan in each county. This would give all low-income Exchange enrollees the option to enroll in a low-cost plan in which continuity of care is assured if the individual's income falls below 138% of FPL. It would provide the same benefit to Medi-Cal beneficiaries to ensure they would not have to switch their provider if their income changes. The Exchange could contract with all Medi-Cal-participating plans in counties where two or more plans operate, but this approach comes with a significant drawback: it could make coverage through a mainstream plan unaffordable for many beneficiaries.[17]
- **Open up the Medi-Cal managed care contracting process to allow additional plans to participate, and establish incentives for Exchange plans to participate in Medi-Cal.** Another option is to establish financial and non-financial incentives for health plans that participate in the Exchange to

The Basic Health Program Option

Related to how to best serve low-income consumers and how to maintain continuity across programs and plans is the question of whether California should pursue a Basic Health Program (BHP). Under a BHP, consumers between 138% and 200% of the federal poverty level (FPL) would be enrolled in a new state program that provides coverage at a lower premium than comparable coverage through the Exchange. The BHP holds promise for improving affordability for its target population and improving continuity of coverage for people moving across the 138% FPL threshold. However, open questions remain about key design features of the BHP and its impact on the Exchange's risk mix and negotiating leverage, enrollees' access to care, and state costs.[16] If California were to create a BHP, much of the rationale for and benefits to the Exchange of partnering with Medi-Cal as described in this paper would certainly extend to partnering with the BHP in the context of beneficiaries whose incomes fluctuate above and below 200% of the FPL.

Managed Care Enrollment in California

Only three of the 27 plans that offer coverage to privately insured individuals contract with Medi-Cal: Anthem Blue Cross, HealthNet, and Kaiser. Moreover, although these three plans account for 64% of total managed care enrollment in California, they account for only 38% of Medi-Cal managed care enrollees. This difference is due to two factors. The first is that access to commercial plans is restricted by Medi-Cal: Among the 27 counties where Medi-Cal managed care is available, Medi-Cal offers no commercial health plan option in the 11 counties with a County-Organized Health System, and it offers only one commercial health plan option in 12 counties. The second is that the state's largest health plan, Kaiser, tightly restricts Medi-Cal enrollment in most counties in which it is available. Kaiser accounts for 40% of California HMO enrollment but only 4% of Medi-Cal managed care enrollment.

The provider networks available to Medi-Cal beneficiaries are also different, even among those enrolled in commercial plans. Blue Cross and HealthNet create different provider networks for their Medi-Cal beneficiaries because many providers will not accept payment rates that are based on Medi-Cal's low fee-for-service rates. Medi-Cal fee-for-service physician fees average only 56% of Medicare fees (and Medicare reimbursement is less than commercial reimbursement).[18] Health plans participating in Medi-Cal have indicated they must often pay their physicians more than Medi-Cal fee-for-service rates in order to ensure sufficient access to care for their members.[19] Their networks for Medi-Cal beneficiaries are also more likely to include traditional safety-net providers such as Federally Qualified Health Centers and public hospitals, which receive enhanced Medicaid reimbursement under federal law.

Table 1. Share of Managed Care Enrollment, by Health Plan Type, 2011

	NUMBER OF PLANS	SHARE OF MEDI-CAL MANAGED CARE ENROLLMENT	SHARE OF ALL HMO ENROLLMENT IN CALIFORNIA
Health Plans Participating in Medi-Cal			
Local Initiatives	9	23%*	7%
County-Organized Health Systems	5	19%*	6%
Other Plans with Public Program Focus	6	20%	6%
Commercial Plans with Medi-Cal and Commercial Members	3	38%	64%
Health Plans Not Participating in Medi-Cal			
Commercial and Other	22	0%	17%
TOTAL	**45**	**100%†**	**100%**

*Excludes members enrolled in a commercial or other plan for their care.

†Members enrolled in managed care account for 57% of Medi-Cal beneficiaries. The remaining 43% of Medi-Cal beneficiaries — including beneficiaries in 31 counties that have no health plan option available to them — receive care through the fee-for-service system.

Source: Estimates based on Medi-Cal enrollment in August 2011 from the DHCS and Medi-Cal managed care enrollment by plan in April 2011. Adjustments for Medi-Cal managed care members who enroll in a subcapitated plan based on worksheet prepared by Cattaneo and Stroud, which reflects enrollment in March 2011.

also participate in Medi-Cal. The Exchange could offer financial incentives modeled after the Healthy Families Premium Discount Program, in which the premiums are discounted for health plans designated as "Community Provider Plans." That designation is used to reward health plans based on their contracts with "traditional and safety-net providers," but a similar approach could be used to reward plans that participate in both the Exchange and Medi-Cal. Similarly, Medi-Cal could offer non-financial incentives through its default enrollment algorithm, which is currently used to assign a higher share of members who don't make a health plan choice of their own to the health plan that scores highest based on a combination of quality measures and safety-net participation.

This approach would require Medi-Cal to open up its County-Organized Health System and two-plan models of managed care, which operate in 25 of the 27 counties in which Medi-Cal managed care is available. These models would be replaced with a county-based, regional, or statewide Geographic Managed Care-type model. Medi-Cal, however, may not want to open up its contracting to include more commercial plans. Medi-Cal's one-plan and two-plan models of managed care provide a level of financial protection to traditional safety-net providers who provide a disproportionate share of care to low-income Medi-Cal and uninsured individuals. These closed systems also allow participating plans to keep their marketing costs low, which allows Medi-Cal to pay less to the plans than it would otherwise.

Even if Medi-Cal opened up its contracting process, it is not clear that modest incentives would be sufficient for convincing large commercial plans like Kaiser or Blue Shield to participate in Medi-Cal if they do not already. Another limitation of this approach is that, although it would allow enrollees whose income falls below the threshold to maintain coverage through their same plan, it may not improve continuity of care. As discussed in the sidebar, "Managed Care Enrollment in California," due to Medi-Cal's low payment rates, commercial plans have created different provider networks in their commercial lines of business than in their Medi-Cal lines.

- **Require Exchange plans to participate in Medi-Cal as a condition of participating in the Exchange.** The Exchange could require health plans that want to participate in the Exchange to also participate in Medi-Cal. A drawback is this may not advance continuity of care if participating health plans establish different provider networks for the two groups. Moreover, there is a risk to both the Exchange and Medi-Cal that some health plans may decide not to participate in the Exchange under these rules, or that health plans may require higher capitation rates under one or both programs to participate. Commercial plans interested in becoming Exchange QHPs may or may not be interested in taking on Medi-Cal. Medi-Cal capitation rates are among the lowest Medicaid rates in the country, and many Medi-Cal beneficiaries have different and more complex needs than the commercial population. Also, as discussed above, Medi-Cal may resist opening up its contracting process to include more commercial plans.

- **Require Medi-Cal plans to participate in the Exchange as a condition of continued participation in Medi-Cal.** Like many of the options, this would require the approval of Medi-Cal. It is not certain that all Medi-Cal-participating plans would want to participate in the Exchange, or that they would be capable of participating (i.e., have experience managing risk), or that they would be allowed to by their governing boards. Also, depending on the requirements set by the Exchange Board, some Medi-Cal plans may need to raise substantial new capital to handle premium collection and marketing. These plans would have to meet a new set of rules, as well as additional accreditation and financial

reserve requirements, and meet rules that require each plan to offer every insurance type (from "precious metals" to catastrophic). In addition, expanding into new markets may not align with the mission or operational and political capabilities of some regional, nonprofit Medi-Cal plans. Therefore, a CHBE that prioritized the needs and options available to Medi-Cal enrollees would make an effort to clarify participation requirements sooner rather than later, and might place greater weight on the needs and constraints of Medi-Cal managed care plans than, for example, the needs and demands of plans that participate only in the commercial market.

Health Plan Requirements

Analysts predict that 8 to 10 million Californians will be eligible for Medi-Cal when the expansion takes place in 2014, with individual Exchange enrollment growing to nearly 4 million by 2016, including 2 million eligible for subsidies and another 1.8 million individual policy holders without subsidies.[20]

A public-partner Exchange would use the procurement process to leverage the combined purchasing strength of the CHBE and Medi-Cal to improve the health care and health outcomes of enrollees of both purchasers. It would work closely with Medi-Cal to identify opportunities to align contract standards, quality improvement goals and activities, payment policies, and health plan contracting and oversight.

Consumer Protections and Other Contract Standards

Medi-Cal's consumer protections have historically exceeded the protections mandated in The Knox Keene Act, and California's §1115 Comprehensive Demonstration Waiver further expands these protections.[21] To achieve administrative simplification and better serve low-income consumers, a public-partner Exchange would seek to develop common consumer protection standards with Medi-Cal in the following areas:

- **Access.** The Exchange would seek to implement the same standards as Medi-Cal for access to providers and for availability of culturally-appropriate information accessible to people with disabilities and low literacy.
- **Care management and coordination.** Exchange plans would offer robust, culturally sensitive care management to enrollees. This would include early identification of members' needs, development of a formal care plan for high-risk individuals, and coordination with other health care services used by members, including behavioral health care, community-based care for members with disabilities, and specialty care for children enrolled in the California Children's Services program.
- **Performance monitoring and improvement.** The Exchange would incorporate many of the same health plan performance monitoring measures used by Medi-Cal so that low-income consumers could compare performance across plans and programs.
- **Grievances and appeals.** Exchange plans would align their grievance and appeals processes as closely as possible with the Medi-Cal process. DHCS requires all health plans to maintain a Member Grievance System, and provides complaint resolution support through the DHCS Ombudsman Program's toll-free telephone line. At any time during the grievance process, beneficiaries or their representatives may request an investigation through the state's hearing process. Requiring consistency across programs would streamline administrative processes, decrease confusion for Medi-Cal and Exchange plan participants, and help them to navigate this process.

The Exchange should not simply adopt Medi-Cal's consumer protections and health plan standards. Rather, the objective should be for the Exchange and Medi-Cal

to work together to identify a set of protections and standards that reflect current best practices. Some differences between the Exchange and Medi-Cal are inevitable.

Quality Improvement

A public-partner Exchange would work closely with Medi-Cal to align their quality measurement and quality improvement activities. This would include:

- **Developing mutually agreed-upon priorities.** The Exchange and Medi-Cal would collaborate to determine a set of common quality measures, and to determine which populations and which problems to target for intervention. For example, the two might collaborate to prioritize quality improvement projects that also seek to reduce costs, such as projects targeting inappropriate emergency room use or inappropriate Caesarean sections.
- **Pursuing common interventions to achieve improvement goals.** The two purchasers would adopt identical evidence-based protocols, team up on technical assistance collaboratives with both Exchange and Medi-Cal plans, and adopt a unified approach to health plan performance incentives.
- **Providing consumers with a unified report card on health plan performance.** A unified, easy-to-use report card to inform consumers as they make their health plan and provider selections would be less expensive to produce than two separate report cards. It would offer other benefits as well, such as improving the statistical power of comparisons of quality and consumer satisfaction by health status, language spoken, and other variables.

The programs would continue to differentiate themselves when it makes sense. For example, Medi-Cal is likely to include measures and quality improvement initiatives that reflect characteristics common in its enrollees, such as a higher incidence of serious mental illness or greater utilization of community-based long-term care than in the Exchange population.

Safety-Net Protections

Most low-income Californians will be eligible for coverage through Medi-Cal or for tax subsidies through the Exchange. However, many low-income individuals will continue to rely on the health care safety net, such as those who are ineligible for public programs, those who are exempt from the mandate, and those who choose not to enroll. Many Medi-Cal enrollees also rely on the safety net, either because they choose to get their care from a safety-net provider or they are unable to find an available provider in another setting.

An Exchange that partners with Medi-Cal would pursue other means to protect and improve the safety net. For example, the Exchange could develop a pay-for-performance system that incorporates safety-net participation as one measure of health plan performance, modeled after Medi-Cal's auto-assignment algorithm.[22]

Health Plan and Provider Payment

Payment methods and rates are among the most powerful tools in a purchaser's toolkit, and the combined purchasing power of Medi-Cal and the Exchange would be immense. As discussed above, Medi-Cal has among the lowest health plan and physician payment rates nationally, and the Exchange should not seek to model its rates after Medi-Cal. However, a public-partner Exchange and Medi-Cal could align their payment methods, possibly to include a common method for risk adjusting health plan capitation rates and a unified approach to health plan performance incentives.

A public-partner Exchange would move cautiously with respect to establishing health plan payment levels. Medi-Cal's low provider payment rates already limit access to providers through the program; the Exchange could potentially exacerbate this problem. If Exchange plans are able to reimburse providers at a much higher

rate than that offered by Medi-Cal (because these plans receive higher reimbursement from the Exchange than from Medi-Cal), then providers might be able to fill their practices with newly insured Exchange enrollees and significantly limit or terminate their participation in Medi-Cal, resulting in potential access problems for Medi-Cal beneficiaries. If the supply of Medi-Cal providers were to become acutely limited, the state may need to increase reimbursement rates for Medi-Cal providers. Alternatively, if Exchange plans reimbursed providers at rates similar to Medi-Cal, provider participation in the Exchange could suffer and some providers might choose to practice in another state.

Administration

There are numerous opportunities for the Exchange and Medi-Cal to collaborate on procurement-related activities in order to keep administrative costs low for themselves and for participating health plans. For example, together the programs could implement a single, cost-effective means for determining eligibility and enrolling people into any program for which they qualified.[23] They could jointly conduct outreach activities and pursue opportunities to use the same personnel to conduct activities such as health plan contracting and oversight, rate setting, medical review, and quality improvement.

There may also be administrative functions the Exchange should conduct separately because collaboration might interfere with the Exchange's ability to take risks and innovate. Healthy Families provides a useful case study in this regard (see sidebar, "The Healthy Families Experience").

The Healthy Families Experience

The experience of the Healthy Families program provides a real-life example of the opportunities and challenges associated with partnering with Medi-Cal. Staff of the Managed Risk Medical Insurance Board (MRMIB), which runs Healthy Families, and of DHCS, which operates Medi-Cal, have worked together in several areas, including the development of a streamlined paper application for coverage under both programs, development and testing of Health-e-App (an online application for children and families), and outreach to consumers.

MRMIB and DHCS have also pursued different paths in many key areas. The managed care programs of Healthy Families and Medi-Cal are quite different, and the two entities have not collaborated as much as they might have in terms of establishing health plan contract standards, quality measures, and performance incentives. For example, both have adopted performance incentives (the Healthy Families Preferred Provider Program, and Medi-Cal's default assignment algorithm), but they have chosen different measures of health plan performance. Also, Healthy Families pioneered the use of certified application assistants and public access to Health-e-App, which might not have been possible if collaboration with Medi-Cal in these areas had been required.

Customer Service Issues

While many of the service needs and expectations of low-income consumers are the same as other consumers, a public-partner CHBE would be particularly attuned to the service needs of lower-income enrollees who move across programs as their income shifts. For example, as discussed above, a public-partner Exchange would need to offer culturally appropriate services suitable for addressing the diverse needs of Medi-Cal beneficiaries. Materials would be available at appropriate reading levels, in different languages, and in alternative formats.

Low-income applicants will want to know which programs they are likely to qualify for and how much of a subsidy they will receive. Ideally, they would enter

information only once — whether entering it through an Exchange portal or when completing an application with the assistance of a county eligibility worker — and have that information available the next time they need it. And, as discussed previously, an Exchange focused on serving Medi-Cal beneficiaries would make extensive use of "navigators" to provide community outreach and assistance to Medi-Cal populations. These navigators would provide information to help low-income individuals determine if they would need to switch plans or providers if their income fluctuated above or below 138% of FPL.

Other customer service aspects of the Exchange would be of benefit to all consumers, whether low-income or not. For example, the Exchange would implement an easy-to-use online system that allows consumers to view and compare their choices, and a toll-free number in case they want to talk to a person to answer a question, get help completing their application, or address other problems or issues.

Public Program Implications

A public-partner Exchange would, by definition, be highly attuned to its impact on and relationship with other public health coverage programs. The Exchange would work to promote and support not just Medi-Cal, but to some extent also Healthy Families and other public programs, including CalWORKs and CalFresh. This type of coordination would provide families with immediate assistance and would eventually lead to improved overall health among those served.

The vision of the Exchange as a partner with Medi-Cal cannot be realized unless Medi-Cal wants to partner and takes appropriate steps to do so. Specifically, Medi-Cal must modify its systems and processes to accommodate the Exchange as a partner. This may include sharing staff, jointly procuring services, considering the perspectives of the Exchange and Healthy Families when establishing its program priorities, and altering some of its policies and practices.

For example, Medi-Cal should consider whether to provide 12 months of continuous eligibility in order to reduce churn. Also, Medi-Cal should consider its models of managed care, which limit beneficiaries' choice of plans to one or two. These models were developed when Medi-Cal managed care enrollment was much smaller that it is now — and a fraction of what it will be in 2014. There will also be a significant decline in the number of uninsured, which these models were designed to protect. Finally, for a public-partner Exchange to thrive, Medi-Cal's administration must be open to a more transparent model of governance, since meetings and decisions of the CHBE are open to the public.

Even if Medi-Cal and the CHBE are able to align themselves at the outset, this collaboration could be difficult to maintain over time due to changes in leadership and program goals and priorities. The two organizations may want to consider articulating a formalized governance and decision-making structure to ensure continued collaboration over time.

Role of the Board and Staffing Requirements

Closely aligning CHBE and Medi-Cal would require putting structural mechanisms in place to ensure significant staff coordination and collaboration over the long term. A public-partner CHBE would ensure there was adequate staff responsible for:

- Coordinating performance measurement and quality improvement activities across the programs
- Ensuring that member services continue to meet the needs of individuals as they move across programs
- Monitoring the financial impact of adverse selection and churning across plans
- Coordinating IT systems

In addition, the CHBE should have a staff person responsible for ensuring regular communication and collaboration with the staff who administer Medi-Cal, and for resolving challenges as they arise. Ideally, at least one board appointee would have deep experience with Medi-Cal, including understanding Medi-Cal finance and the roles of state and federal funds in supporting it.

Just as a public-partner Exchange would align many of its own administrative activities with Medi-Cal, it would also align many of its health plan contract requirements with those of Medi-Cal plans. Aligning health plan contract requirements — such as the data that health plans are required to collect and provide to the Exchange and to Medi-Cal — would result in lower health plan administrative costs, and these savings could be passed on to the state in the form of lower capitation rates.

To take this concept even further, a public-partner Exchange and Medi-Cal could agree to allow health plans to report their performance outcomes for a particular population (e.g., low-income children) across both programs rather than seeking out and reporting results separately for each. As in many of the areas where the Exchange and Medi-Cal could align, some differences would be appropriate due to differences in the populations or priorities of the Exchange and Medi-Cal.

Integration Between Individual and Small Business Health Options Program (SHOP) Exchanges

A public-partner Exchange would focus first and foremost on the experience of low-income individuals, and would be more concerned about integration and coordination for individuals among public programs than with integrating offerings between the individual Exchange and the SHOP Exchange. As such, the SHOP Exchange may operate with greater independence from the individual Exchange under this model. However, the two exchanges would work together to ensure that information about programs for low-income people would be available to workers losing eligibility for employer-sponsored coverage.

Metrics for Success

For a public-partner Exchange, the ultimate measure of program success would be its ability to provide user-friendly access to quality health care services in a cost-effective manner for low-income Californians. The types of indicators to track would include:

- Percent of Medi-Cal-eligibles enrolled in coverage
- Continuity of coverage for individuals who move between Medi-Cal and subsidy-eligible coverage (e.g., uncovered days per switcher)
- Percent of health plans and providers available to both subsidy-eligible and Medi-Cal-eligible individuals; continuity of provider relationships for populations at up to 200% FPL
- Broad array of consumer satisfaction, access, and quality of care measures, stratified by income, race/ethnicity, language spoken, disability, and type of coverage
- Degree of alignment of quality, process, and consumer satisfaction metrics across Exchange, Medi-Cal, and Healthy Families programs
- Annual change in general fund expenditures for Medi-Cal compared to annual change in general fund revenues

Risks and Unintended Consequences

Aligning the Exchange with Medi-Cal offers many potential benefits and could greatly amplify the impact of the Exchange. It also presents some great challenges. These challenges, described below, could undermine or slow the Exchange's ability to innovate quickly. They could also result in lower enrollment in the Exchange. The California Exchange Board should be aware of the following potential issues that may arise if it pursues the public-partner Exchange approach.

- **Collaborating with Medi-Cal may impede innovation.** To collaborate with Medi-Cal (or any other large purchaser), the Exchange may have to sacrifice the opportunity to test ideas quickly and to immediately adopt ones that work. The process of developing common goals and strategies takes longer when another party is involved and many decisions affecting the Medi-Cal program are made by federal and state policymakers through the legislative process, not by program officials. The process of implementing new approaches within Medi-Cal can take a long time given the size and complexity of the program, and its competing goals and shifting priorities also tend to slow innovation. For example, Medi-Cal's goals of improving the health care and health outcomes of its members may be at odds with other goals, such as slowing the growth of state spending by cutting benefits or raising copayments. Many aspects of Medi-Cal are also county-based, such as its eligibility determination process and its managed care program, which may impede state-based or regional solutions.

- **Collaborating with Medi-Cal could lead to lower enrollment in the Exchange.** Alignment with Medi-Cal may turn off potential participants if the Exchange is viewed as being a state "welfare" program. This issue was a key consideration when the state designed Healthy Families. While much has been done at the federal and state levels to de-link Medi-Cal from welfare (e.g., elimination of the face-to-face interview requirement), there is still room for improving the customer experience with Medi-Cal, from the enrollment process, to finding a trustworthy provider in a satisfactory setting, to getting authorization for needed services. If consumers seeking coverage through the Exchange have a poor experience because of policies the Exchange has adopted in order to align itself with Medi-Cal, this could adversely affect Exchange enrollment and its long-term viability. Also, if a public-partner Exchange dials back outreach activities in order align itself with Medi-Cal, it could sacrifice enrollment and its own revenues.

- **Collaborating with Medi-Cal could lead to adverse selection of sicker individuals into the Exchange and drive up costs for all Exchange participants.** A public-partner CHBE could exacerbate adverse selection if relatively healthy, higher-income people are put off by the Exchange's link to public programs. This in turn could drive up premiums for all potential customers and lead to further enrollment declines and adverse selection.

- **Collaborating with Medi-Cal may make it more difficult for the Exchange to partner with other public or private purchasers.** Due to limited resources and a broad set of needs — especially during the start-up phase of a large, complex organization — there will inevitably be competing demands for time and focus. There is a risk that a focused effort on public programs could result in less attention by the CHBE toward creating viable partnerships with commercial plans and, through them, opportunities to influence a broader set of provider relationships and care delivery arrangements. Similarly, if decisions resulting from a partnership with Medi-Cal result in commercial plans being discouraged from participating in the Exchange on a broad scale, the CHBE will be unlikely to have the transformative effect on the health insurance marketplace envisioned in the ACA.

Conclusion

The creation of CHBE offers an unprecedented opportunity for California to ensure that the health care needs of all Californians — including the state's most vulnerable citizens — are met. At one extreme, California could create a system that is purely market-driven and market-focused with only legislatively required ties to entitlement programs. Conversely, California could use its existing publicly funded coverage programs as the foundation for its CHBE and closely align these programs.

There are many advantages to tying the CHBE closely to Medi-Cal. Such a linkage could support seamless access to care when people inevitably move between coverage options. A CHBE tied to Medi-Cal could also benefit from the combined purchasing power of a coordinated system to drive quality improvement and greater efficiency.

However, a closely aligned system also has several drawbacks depending on the choices made. A public-partner CHBE would navigate these challenges driven by its ultimate goal of meeting the health care needs of low-income Californians while creating a system that is administratively and fiscally sustainable.

Project Contributors

CHCF Project Lead

Marian Mulkey

Primary Contributors

Lori Chelius
Lesley Cummings
Rick Curtis
Suzanne Gore
Patrick Holland
Emma Hoo
Ann Hwang, MD
Carolyn Ingram
Jon Kingsdale
Ed Neuschler
Chris Perrone
Sandra Shewry
Nancy Wise
Lucien Wulsin

About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Endnotes

1. Congressional Budget Office, analysis of HR4872 (Reconciliation Act of 2010) and HR 3590 (Patient Protection and Affordable Care Act) as published in letter dated March 20, 2010 to House Speaker Nancy Pelosi. Estimate for increase in Medicaid coverage includes expected enrollment growth in the Children's Health Insurance Program.

2. Published estimates of the projected increase in Medi-Cal enrollment range from 1.7 to 3.0 million, depending on a variety of assumptions including take-up rates among those eligible. Enrollment growth of this magnitude represents a 23% to 41% increase over Medi-Cal's current enrollment of 7.4 million. Such growth would bring total Medi-Cal enrollment from 9.1 to 10.4 million people. As of the 2010 Census, the California population was 37.3 million people.

3. California Health Interview Survey, 2009, accessed August 3, 2011 using askCHIS. Comparison of self-reported health status by poverty level.

4. California HealthCare Foundation, *Medi-Cal Facts and Figures,* 2009.

5. B. Sommers and S. Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back And Forth Between Medicaid And Insurance Exchanges," *Health Affairs* (February 2011).

6. Affordable Care Act §1002.

7. Affordable Care Act §1311(i).

8. 2007 California Health Interview Survey.

9. CMS-2349-P, "Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010," Federal Register 76, no. 159 (August 17, 2011).

10. CMS-9974-P, "Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers," *Federal Register* Vol. 76, no. 159 (August 17, 2011).

11. The CalWORKs program provides temporary financial assistance and employment-focused services to families with minor children who have income and property below state maximum limits for their family size, www.ladpss.org/dpss/calworks.

12. The CalFresh Program, formerly known as Food Stamps and federally known as the Supplemental Nutrition Assistance Program, helps to improve the health and well-being of qualified households and individuals by providing them a means with which to meet their nutritional needs, www.dss.cahwnet.gov/foodstamps.

13. Department of Health and Human Services, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans proposed rule, 76 Federal Register 41866 (July 15, 2011), www.gpo.gov.

14. Annual redetermination and 12 months of continuous eligibility are not synonymous. Continuous eligibility guarantees eligibility even if income rises, whereas annual redetermination does not.

15. R. Curtis and E. Neuschler, "Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population: Background and an Alternative Approach," Institute for Health Policy Solutions (July 2011).

16. For further analysis on the Basic Health Program option, see Mercer, "State of California Financial Feasibility of a Basic Health Program" and Institute for Health Policy Solutions, "Continuity for (Former) Medi-Cal Enrollees and Affordability for the Low-Income Exchange Population," both available at www.chcf.org.

17. Ibid.

18. S. Zuckerman, A. Williams, and K. Stockley, "Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare," California HealthCare Foundation (April 2009).

19. J. Mittler and M. Gold, "Building and Sustaining Physician Networks in Medi-Cal Managed Care and Healthy Families," California HealthCare Foundation (May 2003).

20. Two estimates converge on this figure. First, Peter Long and Jonathan Gruber, in "Projecting the Impact of the Affordable Care Act on California," *Health Affairs* 30, no.1 (2011): 6370, estimate the Exchange size in California will be 4 million in 2016, but, per personal communication with Dr. Gruber, this estimate includes all non-grandfathered individual coverage. (With grandfathered plans included, the individual market also totals 4.9 million.) Dr. Gruber reports that individual tax-credit recipients will total about 2 million. Second, the UC Berkeley Labor Center and the UCLA Center for Health Policy Research also project 2 million individual Exchange enrollees with subsidies in 2016, and 1.8 million individual policyholders without subsidies (Jerry Kominski, "The Potential Impact of the Affordable Care Act on California," Presentation to CHBE at May 11, 2011 meeting).

21. Examples include Medi-Cal contract standards that require participating health plans to: (1) conduct a health risk stratification of newly enrolled members and administer a DHCS-approved health risk assessment survey within 45 days for members deemed to be at a higher risk; (2) conduct facility site reviews to assess the physical and non-physical accessibility of provider facilities; (3) provide continued access for up to 12 months to an out-of-network provider with whom the member has an ongoing relationship if the provider will accept the higher of the health plan's payment rates or Medi-Cal fee-for-service rates; and (4) submit procedures to DHCS for administering and monitoring the provision of complex care management.

22. The Medi-Cal auto-assignment algorithm scores health plans based on the quality of care they provide (using selected HEDIS measures) and level of safety-net participation. The measures of safety-net participation include the percent of hospital discharges of Medi-Cal members from disproportionate share hospitals and the percent of members assigned to Federally Qualified Health Centers (and certain other safety-net providers) as their primary care physician. Health plans with higher scores are rewarded with a greater share of auto-assigned members — that is, Medi-Cal beneficiaries required to enroll in managed care who do not select a health plan.

23. For example, see California HealthCare Foundation, "Modernizing Enrollment in California's Health Programs for Pregnant Women and Children: A Blueprint for the Future" (September, 2007).